Appendix 406-B

Emergency Medical Authorization Form

Student Name: _____ Home Room: _____

Address: _____ Phone: _____

Purpose – To enable parent(s)/guardian(s) to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parent(s) or guardian(s) cannot be reached.

Residential Parent(s)/Guardian(s):

Mother's Name: _____ Daytime Phone: _____

Father's Name: _____ Daytime Phone: _____

Other's Name: _____ Daytime Phone: _____

Name of Relative or Childcare Provider: _____ Relationship: _____

Address: _____ Daytime Phone: _____

PART I – TO GRANT CONSENT (PART I OR PART II MUST BE COMPLETED)

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone: _____

Dentist _____ Phone: _____

Med. Specialist _____ Phone: _____

Local Hospital _____ ER Phone: _____

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated practitioner is not available, by another licensed physician or dentist, concurring in the necessity for transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____

_____

PART II – REFUSAL TO CONSENT (DO NOT COMPLETE IF COMPLETED PART I)

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

Signature of Parent/Guardian: _____ Date: _____

Address:_____